STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: IOWA

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Services	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Prescribed drugs (Copayment is for each covered prescription and refill)			X	$1.00 for generic and preferred brand-name drugs $1.00 for nonpreferred brand-name drugs for which the cost to the state is no more than $25.00 $2.00 for nonpreferred brand-name drugs for which the cost to the state is $25.01 to $50.00 $3.00 for nonpreferred brand-name drugs for which the cost to the state is $50.01 or more For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or any rebates received. For this purpose, any brand-name drug not subject to prior approval based on non-preferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.
Chiropractors			X	$1.00 for total amount of service provided during a given date.*
Independently practicing physical therapist			X	$1.00 for total amount of service provided during a given date.*

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Services	Type of Charge			Amount and Basis for determination
	Deduct.	Coins.	Copay.	
Podiatrists			X	$1.00 for total amount of service provided during a given date.*
Medical equipment and appliances, prosthetic devices and sickroom supplies			X	$2.00 for total amount of service provided during a given date.*
Orthopedic shoes			X	$2.00 for total amount of service provided during a given date.*
Audiologists services (including medical supplies provided by the audiologist but excluding hearing aids)			X	$2.00 for total amount of service provided during a given date.*
Optometrists			X	$2.00 for total amount of service provided during a given date.*
Opticians			X	$2.00 for total amount of service provided during a given date.*

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Services	Type of Charge			Amount and Basis for determination
	Deduct.	Coins.	Copay.	
Rehabilitation agencies			X	$2.00 for total amount of service provided during a given date.*
Psychologists			X	$2.00 for total amount of service provided during a given date.*
Ambulance services			X	$2.00 for each date of service*
Dental services			X	$3.00 for total amount of service provided during a given date.*
Hearing Aids			X	$3.00 for total amount of service provided during a given date.*
Physician office visits			X	$3.00 for total covered services provided in a physician office visit, rendered on a given date of service.** For purposes of this provision, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.)

* The basis for the copayment is the statewide average payment for all service provided one recipient by one provider on a single date. Averages were computed from claims paid during fiscal year 1982.

** The basis for the copayment is the statewide average payment for all service provided one recipient by one provider on a single date. Averages were computed from claims paid during state fiscal year 2003.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Iowa

B. The method used to collect cost sharing charges for categorically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Recipients can assert to the provider that they are unable to pay the charge. The Medicaid manual issued to all enrolled providers instructs that they can not deny care or services to any Medicaid recipient because of the recipient's inability to pay a copayment. Only nominal copayments are assessed. The agency has a Medicaid Hotline established for use by Medicaid recipients who feel they have been inappropriately billed by a health care provider. Specific follow-up responsibilities and timeframes are established for the Medicaid agency to investigate the complaint, respond to the recipient, and correct the situation if an error exists.

Recipients who believe the copayment was incorrectly applied can call the Medicaid Hotline (toll free) to receive a notice of decision which explains the recipient's appeal rights.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Iowa

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

1. The Medicaid agency issues a manual to all providers that identifies the services that are subject to copayment, the amount of the copayment to be imposed and the categories of recipients and services that are excluded from copayment.

2. The manual instructs providers that they may not deny care or service because of the recipient's inability to pay a copayment.

3. Recipients also receive information advising when exclusions from copayment apply.

4. Copayments are applied to all medical services with these specific exemptions.

Exemption to Copayment	Enforcement Provided
Persons under age 21	The recipient's birthdate is recorded on the medical ID card. Providers can view the medical ID to apply the exemption.
Family planning services or supplies	The family planning clinic service and genetic consultation clinic service provider groups have not been assigned a copayment. Other providers use a Z2 modifier to denote family planning services. Claims with a Z2 modifier are exempt from copayment. Use of the Z2 modifier is explained in the provider manual.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Iowa

Exemption to Copayment	Enforcement Provided
Persons receiving care in a nursing facility, state mental health institution, or other medical institution if the person is required to spend, for costs of necessary medical care, all but a minimal amount of income for personal needs.	If a person is residing in a facility, an institutional eligibility file is established. This file is used during the processing of a Medicaid claim. If it shows the recipient residing in an institution on the date of service, no copayment is applied.
Pregnant women	Instructions for all claim forms for services on which copayment is applicable were modified to add a statement "check box if recipient was pregnant at the time services were rendered." If there is a check in the box, the MMIS will not apply to copayment. Additionally, provider groups who serve primarily pregnant women have been exempted from copayment. These providers are: birthing centers, family planning clinics, maternal health centers and nurse midwives.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Iowa

Exemption to Copayment	Enforcement Provided
Emergency services defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in: 1. Placing the patient's health in serious jeopardy, 2. Serious impairment to bodily functions, or 3. Serious dysfunction of any bodily organ or part.	The list of diagnoses codes used by MMIS to determine the emergency exemption has been placed in the provider manual.
Recipients enrolled in an HMO contracting with the Department to provide Medicaid service.	The MMIS system reviews the medical file and does not deduct a copayment when HMO enrollment is found.

E. Cumulative maximums on charges:

__X__ State policy does not provide for cumulative maximums.

_____ Cumulative maximums have been established as described below: